

# Community Health Plan of Washington Medicare Advantage



**COMMUNITY HEALTH PLAN**  
of Washington™  
**MEDICARE ADVANTAGE**

## 2024 Notice Formulary Drug List Changes - 5 Tier Effective 06/01/2024

Community Health Plan of Washington™ may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug, we will notify you of the change at least 60 days before the date that the change becomes effective.

However, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market we will immediately remove the drug from our formulary. For more recent information or other questions, please contact Community Health Plan of Washington Medicare Advantage Customer Service:

Current Members: 1-800-942-0247  
Prospective Members: 1-800-944-1247  
TTY Relay: Dial 711  
medicare.chpw.org

The table below outlines upcoming changes to our formulary that will impact you:

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., RISPERDAL) and generic drugs are listed in lower-case italics (e.g., *risperidone*).

Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
<i>clindamycin 1 % topical gel</i>	06/01/2024	Formulary Addition	Tier 3	QL
<i>sumatriptan 4 mg/0.5 ml subcutaneous pen injector</i>	06/01/2024	New Drug	Tier 4	QL
VRAYLAR 1.5 MG (1)-3 MG (6) CAPSULES IN A DOSE PACK	06/01/2024	New Drug	Tier 4	QL
<i>clindamycin 1 % topical gel</i>	06/01/2024	Removed from Formulary		*Alternative

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Name of Affected Drug	Date of Change	Reason for Change	Tier	Restriction
<i>clindamycin 150 mg/ml injection solution</i>	06/01/2024	Removed from Formulary		*Alternative
<i>nitroglycerin 0.4 % (w/w) rectal ointment</i>	06/01/2024	Removed from Formulary		*Alternative
<i>theophylline er 100 mg tablet, extended release, 12 hr</i>	06/01/2024	Removed from Formulary		*Alternative
<i>theophylline er 200 mg tablet, extended release, 12 hr</i>	06/01/2024	Removed from Formulary		*Alternative
ZYMFENTRA 120 MG/ML SUBCUTANEOUS PEN KIT	06/01/2024	Removed from Formulary		*Alternative
ZYMFENTRA 120 MG/ML SUBCUTANEOUS SYRINGE KIT	06/01/2024	Removed from Formulary		*Alternative

\*Alternative drugs are drugs in the same therapeutic category/class or cost-sharing tier as the affected drug. Only your physician can determine if the alternate listed here is appropriate for you given the individualized nature of drug therapy. Please consult with your physician as to whether this is an appropriate drug for you.

## List of Abbreviations

**LA:** Limited Availability. This medication may only be available at certain pharmacies.

**PA:** Prior Authorization. The Plan requires you or your physician to get prior authorization for certain medications. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the medication.

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**QL:** Quantity Limit. For certain drugs, the Plan limits the amount of the medication that we will cover.

**ST:** Step Therapy. In some cases, the Plan requires you to try certain drugs first to treat your medical condition before we will cover another drug for that condition.

Community Health Plan of Washington is an HMO plan with a Medicare contract. Enrollment in Community Health Plan of Washington depends on contract renewal.